U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue date: 27Mar2002

CASE NOS.: 2001-BLA-279
2001-BLA-280

In the Matter of

MARGARET R. EARL, o/b/o and as
Survivor of WILLARD L. EARL,
Claimant

v.

CONSOLIDATION COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Dannette Constantino, Lay Representative
For the Claimant

William S. Mattingly, Esquire
For the Employer

Before: ROBERT J. LESNICK
Administrative Law Judge

DECISION AND ORDER ON MODIFICATION REQUEST - AWARDING BENEFITS

This proceeding arises from claims for benefits filed by Willard L. Earl, a now deceased coal miner, and Margaret R. Earl, his surviving spouse, under the Black Lung Benefits Act, 30 U.S.C. §901,

et seq. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on July 12, 2001 in Morgantown, West Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued. Furthermore, the record was held open for the submission of additional evidence and post-hearing briefs. The supplemental report of Dr. Joseph J. Renn, dated August 10, 2001, which was submitted under cover letter dated August 13, 2001, marked and received as Employer's Exhibit 6 (EX 6). Furthermore, I have, *sua sponte*, marked and received, as Administrative Law Judge Exhibit 2 (ALJX 2), the Benefits Review Board's Decision and Order, dated May 22, 1998, which relates to the miner's claim herein. In addition, I have considered the parties' post-hearing arguments, including Claimant's "Response to July 2001 Testimony Given by Dr. Morgan & Dr. Renn for Consolidation Coal Company On Behalf Of Willard Earl & Margaret Earl," dated July 20, 2001, Claimant's Brief, dated September 24, 2001, and Employer's Closing Argument, dated September 28, 2001.

In summary, the record consists of the hearing transcript, Director's Exhibits 1 through 91, *except* Director's Exhibit 64, which pertains to a different miner (DX 1-91, *except* DX 64), Administrative Law Judge Exhibits 1 and 2 (ALJX 1-2), Claimant's Exhibits 1 through 5 (CX 1-5), and Employer's Exhibits 1 through 6 (EX 1-6). In addition, the above-referenced post-hearing arguments were filed.

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[1]The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The amended Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the amended regulations, however, were to apply only to claims filed on or after January 19, 2001, *not* to pending cases. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order which enjoined the application of the Amendments "except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case."
On February 20, 2001, I issued an Order, whereby I provided the parties an opportunity to address the application of the new amended regulatory provisions. The Employer and Director filed briefs, while Claimant did not. The Employer opposed the use of the new regulations, as violatiive of due process. On the other hand, the Director stated that the "new regulations do not make any substantive changes to the standards for determining coal miner's total disability or death due to pneumoconiosis that would be applicable to this case in the absence of these new regulations." Since I found the District Director's position persuasive, I proceeded with the formal hearing of this matter on July 12, 2001. Moreover, on August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the Preliminary Injunction, and upheld the validity of the amended regulations.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

Miner's Claim:

On May 10, 1977 (DX 89-1) and July 21, 1989 (DX 88-1), Willard L. Earl, a former coal miner, filed applications for black lung benefits under the Act (DX 1). The foregoing claims were denied. The most recent denial was issued by the District Director's office on July 12, 1990 (DX 88-24). The miner did not appeal nor take any further action regarding the 1977 and/or 1989 claims. Therefore, the foregoing claims were finally denied and administratively closed (DX 91).

On or about April 4, 1994, Mr. Willard filed the current claim for benefits under the Act (DX 1), which was granted by the District Director's office. Furthermore, on March 18, 1996, Administrative Law Judge Frederick D. Neusner issued a Decision and Order - Awarding Benefits (DX 54). Following Employer's timely appeal, the Benefits Review Board issued a Decision and Order, dated September 27, 1996, in which Judge Neusner's decision was affirmed in part, vacated in part, and remanded for further consideration consistent with the Board's opinion (DX 55). Subsequently, on May 14, 1997, Judge Neusner issued a Decision and Order on Remand - Awarding Benefits (DX 56), which was affirmed by the Benefits Review Board in its Decision and Order, dated May 22, 1998 (ALJX 2). Moreover, the Employer, through its own carrier, Employers Service Corporation, stated, in correspondence to the District Director, dated October 5, 1998, the following:

> In accordance with the Decision and Order issued by the Benefits Review Board on May 22, 1998, Consolidation Coal Company elected not to pursue further appeal after learning of Mr. Willard's (sic) death. Therefore, we request that an Award Letter be issued, advising the employer of any reimbursement owed to the Black Lung Disability Trust Fund or accumulated benefits owed to the claimant's estate. The employer paid benefits on a prospective basis from May 1996 through April 1998. Enclosed is a Form CM-908 reflecting the termination of prospective benefits to Mr. Earl.

(DX 63).

Following the issuance of a Corrected Award of Benefits by the District Director's office on November 19, 1998, Employers Service Corporation, on behalf of the Employer submitted a letter to the District Director's office, dated December 16, 1998, stating, in pertinent part:

> We are in receipt of your Corrected Award of Benefits issued November 19, 1998. We have reviewed this award and agree with your calculations. Therefore, Employer Service Corporation, on behalf of Consolidation Coal Company, will issue a check in the amount of $10,945.10 to the Department of Labor. This represents interim benefits paid from December 1994 through April 1996. Additionally, a check in the amount of $5,128.80 will be issued to Mrs. Earl on behalf
>
> of the claimant's estate. This represents accumulated benefits due the claimant's estate from April 1994 through November 1994.

(DX 68).

On or about May 10, 1999, however, the Employer filed a Motion for Modification (DX 69). The Employer acknowledged that the Benefits Review Board affirmed the award of benefits in its Decision and Order dated May 22, 1998. Although the Employer had appealed the case to the U.S. Court of Appeals for the Fourth Circuit, Employer voluntarily dismissed the appeal after Mr. Earl's death. The underlying basis cited by the Employer in its Motion for Modification was the consultative opinion of Dr. Jerome Kleinerman, who reviewed not only medical records but also tissue slides from a biopsy performed on March 27, 1998 (DX 69).

Employer's correspondence, dated June 11, 1999, indicates that the District Director had apparently returned the Motion for Modification to Employer's counsel. Accordingly, the Employer reiterated its position in its "Request for Modification of Award in Miner's Claim." (DX 70). Furthermore, Employer stated:

> An administrative law judge is without power to commence the modification proceedings under 20 C.F.R. 725.310. See Lee v. Consolidation Coal Co., 843 F.2d 159 (4th Cir. 1988); Jessee v. Director, OWCP, 5 F.3d 723 (4th Cir. 1993). Accordingly, I request that the District Director initiate modification proceedings and, if necessary, request that the Office of Administrative Law Judges return the living miner's claim, which apparently has been associated with the survivor's claim, that has been forwarded by the District Director to the Office of Administrative Law Judges in association with the request for a hearing on entitlement in the survivor's claim.

(DX 70).

Following the development of additional medical evidence, the District Director issued a Proposed Decision and Order, dated November 15, 2000, in which the District Director, again,

awarded benefits in the miner's claim (DX 82).[2] By letter dated December 8, 2000, Employer filed a timely request for a formal hearing (DX 87-B). The miner's claim was forwarded to the Office of Administrative Law Judges on December 6, 2000 (DX 91).

Widow's Claim:

On May 13, 1998, Willard E. Earl passed away (DX 20). Shortly thereafter, on July 28 1998, his surviving spouse, Margaret R. Earl (hereinafter referred to as "Claimant" or "widow") filed an application for survivor's benefits (DX 2), which was initially granted by the District Director's office on October 28, 1998 (DX 25). The Employer filed a timely Operator Controversion (DX 29). Following the further development of evidence, the survivor's claim was forwarded to the Office of Administrative Law Judges. Thereafter, a formal hearing was held before Administrative Law Judge Gerald M. Tierney on August 5, 1999 regarding the survivor's claim (DX 52, p. 5). Following various procedural and evidentiary developments relating to the miner's and widow's claims, Judge Tierney issued an Order of Remand, dated February 23, 2000, remanding both cases for consolidation (DX 76). In pertinent part, Judge Tierney stated:

> The referral of the modification case for hearing is premature. Initial findings in such cases must be made by the District Director. Therefore, that case must be remanded.
>
> The survivor's case involves the same fundamental issue of the existence of pneumoconiosis. To decide this case separate from the modification proceeding invites conflict and possible duplication of effort. It is, therefore, reasonable to remand this case for consolidation with the living miner's case. The District Director can, therefore, make a decision in both cases on all the evidence.

(DX 76).

Following the Order of Remand, the District Director ruled on the miner's claim, as stated above, and also issued a Proposed Decision and Order, dated November 15, 2000, in which benefits

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[2]The District Director titled his decision as a "Corrected Notice - Proposed Decision and Order Granting Request for Modification." This is somewhat misleading, since the pre-modification decision was also an award of benefits. However, it is clear from the District Director's "Findings of Fact" and "Proposed Order" that benefits were granted (DX 70).

were also awarded in the survivor's's claim (DX 82).[3] By letter dated December 8, 2000, Employer filed a timely request for a formal hearing regarding the survivor's claim, as well (DX 87-B).

As stated above, a formal hearing was held on July 12, 2001; and, the record was held open for post-hearing submissions. Following the receipt of such submissions, the record was closed.

Issues

The primary contested issues in the miner's and widow's claim, respectively, are as follows:

Miner's Claim:

1. Whether the miner had pneumoconiosis as defined by the Act and the regulations.
2. Whether the miner's pneumoconiosis arose out of coal mine employment.
3. Whether the miner's disability was due to pneumoconiosis.
4. Whether the evidence establishes a change in conditions and/or a mistake in a determination of fact pursuant to 20 C.F.R. §725.310.

Widow's Claim:

1. Whether the miner had pneumoconiosis as defined by the Act and the regulations.
2. Whether the miner's pneumoconiosis arose out of coal mine employment.
3. Whether the miner's death was due to pneumoconiosis.

(TR 20-21).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Employment History

A. Coal Miner

[3] The District Director titled his decision in the survivor's claim as a "Corrected Notice - Proposed Decision and Order Granting Request for Modification." This is misleading on two grounds. First of all, the Employer's modification request relates to the miner's claim, not the survivor's claim. Secondly, the survivor's claim was granted, which is consistent with the District Director's earlier finding in the survivor's case (DX 84).

The Employer conceded, and I find, that Mr. Earl engaged in coal mine employment for 37 years, as previously found by Judge Neusner (DX 54, p. 2) and affirmed by the Benefits Review Board (DX 55, note 1). Furthermore, any discrepancy between the 37 years of coal mine employment found and the 41 ½ years alleged in the miner's application for benefits (DX 1) is inconsequential for the purpose of rendering a decision herein.

B. Responsible Operator

The parties stipulated, and I find, that the Employer, Consolidation Coal Company, is the properly designated responsible coal mine operator in this case, under amended Subpart G, Part 725 of the regulations (TR 21).

C. Dependents

The former miner, Willard L. Earl, had one dependent for purposes of possible augmentation of benefits under the Act; namely, his spouse, Margaret R. Earl. However, the Claimant, Margaret R. Earl, has no dependents (DX 1,2; TR 21).

D. Personal and Employment Background and Other Lay Evidence

Willard L. Earl was born on October 13, 1932. He married Margaret R. Earl on April 25, 1951 They remained married until his death on May 13, 1998 (DX 1,2,20).

Mr. Earl left the coal mines on or about July 27, 1991 due to poor health, namely breathing problems (DX 1). His last usual coal mine job was as a mechanic at a coal mine preparation plant, where extracted coal was processed before delivery to the ultimate users. The job entailed moderately heavy exertion, such as lifting, carrying, and moving of tools, equipment, and machine parts. Furthermore, in his last usual coal mine job, as well as his earlier coal mine jobs, he was exposed to considerable coal dust (DX 4,7; DX 54; 10/16/95-Hearing TR 22-28,31-33,37).

Claimant also testified that her husband began suffering from breathing difficulties years before he stopped working (DX 52, p. 11). In addition, the Claimant stated that the miner's breathing condition became "very much worse" over time. Furthermore, prior to his death on May 13, 1998, Mr. Earl couldn't perform physical labor around the house, and even walking was difficult. In addition, the miner had difficulty sleeping and often used an oxygen machine (DX 52, pp. 12-13).

Claimant acknowledged that her husband used to smoke, but she was unable to specify the extent of his smoking history (DX 52, p. 13). As summarized in the Employer's Pre-Hearing Report, taken as a whole, I find that the medical evidence establishes that the miner had a significant cigarette smoking history of approximately 1 pack per day beginning in the 1950's and ending in the late 1980's (ALJX 1; *See, e.g.,* DX 15,20,30A,48,88,89).

Medical Evidence

The case file includes numerous chest x-ray and CT scan readings, biopsy interpretations, pulmonary function studies, arterial blood gas test results, and medical opinions. The Pre-Modification medical evidence was discussed and analyzed in Judge Neusner's decisions, dated March 18, 1996 (DX 54) and May 14, 1997 (DX 56), as well as in the decisions of the Benefits Review Board, dated September 27, 1996 (DX 55) and May 22, 1998 (ALJX 2). Furthermore, almost all of the medical evidence, both old and new, is summarized in the Employer's Pre-Hearing Report, dated July 12, 2001 (ALJX 1). Except as otherwise modified or superseded herein, all of the foregoing medical evidence is incorporated by reference herein. This obviates

the necessity for a complete repetition of such evidence. Nevertheless, this decision is based upon a *de novo* evaluation of all the evidence, both old and new.

A. Chest X-rays and CT Scans

As summarized in Employer's Pre-Hearing Report and confirmed by the record, the record includes extensive x-ray and CT scan evidence which covers the period from August 16, 1977 through May 12, 1998 (ALJX 1, pp. 1-16). The foregoing evidence is conflicting. Many of the findings are descriptive and neither preclude nor establish the presence of pneumoconiosis. A majority of the interpretations which specifically address the pneumoconiosis issue under the classification requirements, including those by B-readers and/or Board-certified radiologists, are negative. However, the record also contains several positive interpretations by similarly well-qualified B-readers and Board-certified radiologists. Therefore, taken as a whole, I find that the x-ray evidence is inconclusive. Accordingly, the Claimant has failed to meet her burden of establishing the presence of pneumoconiosis pursuant to §718.202(a)(1).

In considering Employer's modification request in the miner's claim, I note that the foregoing determination is consistent with Judge Neusner's Decision and Order on Remand - Awarding Benefits (DX 56, pp. 2-4).

B. Biopsy and Related Pathology Evidence

As set forth in Employer's Pre-Hearing Report (ALJX 1) and confirmed by the record, the miner underwent bronchoscopy, thoracotomy, and biopsy procedures during the period from February 25, 1998 until his death (DX 51). The foregoing procedures involved various lymph nodes and the lower left lung lobe. The primary purpose for conducting these procedures was to assess and treat the mass in the miner's left lower lobe, which was diagnosed as lung cancer.

In summary, the record includes the surgical reports and other pathology findings of Drs. Devanbhaktuni (DX 51), Meijanti (DX 51), Graeber (DX 51,20), Chang (DX 80,81), Kleinerman (DX 50,69,72), Garcia (DX 50,71), Perper (DX 81), and Rizkalla (CX 3).

Dr. Devanbhaktuni is a pulmonologist who also reported pathology findings on February 25, 1998 and March 3, 1998 (DX 51; ALJX 1). In brief, Dr. Devanbhaktuni did not find sufficient pathology evidence to diagnose medical or "Clinical Pneumoconiosis," but he nevertheless concluded that the miner established "Legal Pneumoconiosis." (DX 51; Devanbhaktuni Deposition). Since Dr. Devanbhaktuni's finding of "Legal Pneumoconiosis" is based primarily on non-pathology evidence, his opinion is discussed in more detail below.

Dr. Meijanti's report, dated February 25, 1998, pertains to bronchial washings of the left lower lobe. Various findings are reported, but none establish "Clinical Pneumoconiosis." (DX 51; ALJX 1).

Dr. Graeber issued multiple pathology reports, dated March 27, 1998, April 2, 1998, and April 24, 1998. Some of the findings, in particular on the April 2, 1998 surgical pathology report (*e.g.*, anthracotic pigmentation, focal emphysema with interstitial fibrosis), may be suggestive of "Clinical Pneumoconiosis." However, Dr. Graeber did not provide a clear, unequivocal diagnosis of the disease (DX 51,20; ALJX 1).

Dr. Chang issued a Surgical Pathology Report, dated April 2, 1998 with addendum diagnoses, dated April 9, 1999. The foregoing reports were made in conjunction with the procedure performed by Dr. Graeber at West Virginia University Hospital on or about March 27, 1998. In addition, the case file includes an Intraoperative Consult Diagnosis and a Gross Description which were reported by Drs. Cook and Nestor, respectively (DX 81). The foregoing reports include diagnoses and/or findings of kertanizing squamous cell carcinoma, negative for malignancy; focal emphysema with interstitial fibrosis, pulmonary emphysema, and anthracotic pigmentation on various lymph nodes. Simple coal workers pneumoconiosis was not specifically diagnosed (DX 81).

Dr. Kleinerman is a well-credentialed pathologist, who issued a consultation report, dated April 28, 1999 and testified at deposition on June 29, 1999. He concluded that the evidence fails to establish CWP. Moreover, Dr. Kleinerman also opined that Mr. Earl's coal mine dust exposure did not cause or significantly contribute to the miner's respiratory disability or death. Accordingly, Dr. Kleinerman's opinion, if credited, would rule out both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." Thus,

Dr. Kleinerman not only addressed the issue of "Clinical Pneumoconiosis" based on pathology evidence. He also considered the issues of "Legal Pneumoconiosis" and "Causation," and he analyzed some non-pathology medical evidence (DX 50,69,72; ALJX 1). Therefore, Dr. Kleinerman's opinion is also discussed in more detail below.

Dr. Garcia, a well-credentialed pathologist, reviewed various histologic slides and issued a report dated July 7, 1999. His primary finding appears to be squamous cell carcinoma. However, his other pathology findings included focal interstitial fibrosis, emphysema, bronchiectasis, and anthracotic lymph nodes with only focal laden macrophages. Dr. Garcia concluded, in pertinent part, that the "amount of anthracosis present in the lymph nodes and lung parenchyma is compatible with that commonly seen in smokers or city dwellers. There is no evidence of simple coal worker's pneumoconiosis, neither is there evidence of silicosis or complicated pneumoconiosis." (DX 50,71). The essence of Dr. Garcia's opinion appears to be that the miner did not establish medical pneumoconiosis on the basis of the pathology evidence. Furthermore, Dr. Garcia's use of the term "anthracosis" seems, in context, to be a finding of anthracotic pigmentation. On the other hand, the term "anthracosis" is specifically included within the regulatory definition of "Clinical Pneumoconiosis," as stated in §718.202(a)(1). Accordingly, I find that Dr. Garcia's opinion is ambiguous.

Dr. Perper, a Forensic Pathologist and Medicolegal Consultant, issued a report, dated August 28, 2000, which primarily focused on the pathology evidence, while also briefly mentioning some other medical evidence (DX 81). The microscopic diagnoses by Dr. Perper included:

squamous cell carcinoma; centrilobular emphysema, severe with focal interstitial fibrosis; anthracotic pigmentation, minimal to slight, insufficient for diagnosing coal workers' pneumoconiosis; fibro-hyalinocalcific granulomas of undetermined etiology; chronic bronchitis; and lymph nodes with marked anthracotic pigmentation and birefringent silica crystals (DX 81, p. 5). In response to a question regarding whether there is evidence that Mr. Earl had coal workers pneumoconiosis, Dr. Perper answered in the "negative, based on the findings in the resected lower lobe of the left lobe." However, in his response, Dr. Perper opined that "the resected lower lobe of the left lung (does) show a very mild anthracosis." (DX 81, p. 5). As previously stated, "anthracosis" meets the regulatory definition of "Clinical Pneumoconiosis." 20 C.F.R. § 718.201(a)(1). Dr. Perper also stated: "In the unlikely event that someone would accept such a presence, as evidence of pneumoconiosis, it is beyond any reasonable doubt that such a process would be totally insignificant in terms of pulmonary dysfunction, disability or contribution to death." (DX 81, p. 5). I note, however, that Dr. Perper also stated the following:

> One should however point out that the absence of findings of coal workers' pneumoconiosis in the resected lower lobe of the left lung, does not exclude the presence of significant coal workers' pneumoconiosis in the remainder of the lungs. Typically, lesions of CWP are more marked in the upper lobes of the lungs. No autopsy was performed and therefore one cannot answer satisfactorily this problem. Furthermore, in

> the absence of medical records, one cannot determine whether there are clinical, radiological, or laboratory records or pulmonary functions or arterial blood gases, which might help in resolving the issue, whether other pulmonary lobes show evidence of CWP.

(DX 81, p. 8).

Dr. Perper also addressed various other questions, namely: whether Mr. Earl's pulmonary disease or other pathological condition resulted from occupational exposure as a coal miner to coal dust; whether the miner's death was caused or hastened by coal workers' pneumoconiosis, or any other coal mine-related respiratory disease or condition; and, whether the miner's death was in any way related to occupational coal mine dust exposure. In each instance, Dr. Perper answered in the negative based on the findings in the resected lower lobe of the left lung (emphasis added). However, as in his discussion of the pneumoconiosis issue, Dr. Perper qualified his answer by noting that he only had very limited data. Furthermore, Dr. Perper acknowledged that the miner's other significant condition, *i.e.*, severe centrilobular emphysema has been reported to be the result of both exposure to smoking and silica containing coal dust. Furthermore, while concluding that the miner's carcinoma is "likely" due to smoking, he noted that there is some recent, still controversial, medical literature which started reporting pulmonary cancer related to occupational exposure to mixed coal dust containing silica. Moreover, Dr. Perper concluded that, based solely on the reviewed microscopic findings, he could not reliably determine the cause of Mr. Earl's death (DX 81).

Dr. Rizkalla, an Associate in Pathology, issued a consultation pathology report, dated January 16, 2001 (CX 3; ALJX 1). The pathology portion of the report includes a microscopic description of the lung slides and the following final anatomic diagnoses: Well to moderately differentiated squamous cell carcinoma of the left lower lobe of the lung; Bullous emphysema with scar emphysema and interstitial pulmonary fibrosis; and, Simple coal workers' pneumoconiosis. In addition, Dr. Rizkalla noted the following:

> **COMMENT:** Examination of the lung tissue taken from the lower lobe of the left lung displays macular coal workers' pneumoconiosis with severe bullous and scar emphysema. Keeping in mind that the lung tissue obtained was during cancer surgery and may not truly reflect the actual degree of coal workers' pneumoconiosis in the other parts of the lungs. Coal dust tends to affect the apical or upper parts of the lungs, as well as, the upper parts of each lobe. So, anticipating that coal workers' pneumoconiosis was more severe in the deceased's lungs more than in the present material taken through the cancer surgery.

(CX 3).

In addition, Dr. Rizkalla set forth the miner's clinical history and reviewed some non-pathology evidence. Furthermore, Dr. Rizkalla specifically addressed the "Causation" issue. Therefore, Dr. Rizkalla's opinion is also discussed below.

Having carefully reviewed the biopsy evidence, I find that it is conflicting and inconclusive. Only Dr. Rizkalla (CX 3) clearly and unequivocally found pathology evidence of simple pneumoconiosis. On the other hand, Drs. Devanbhaktuni and Kleinerman specifically found that the evidence was insufficient to establish clinical pneumoconiosis. In addition, Drs. Garcia and Perper, who also stated that the biopsy evidence did not establish coal worker's pneumoconiosis, mentioned the presence of "anthracosis" which is listed in the regulatory definition of Clinical Pneumoconiosis. Moreover, Dr. Perper's analysis is instructive regarding the limited nature of the biopsy evidence in this case, and the fact that pneumoconiosis is typically more marked in the upper lobes of the lungs. This analysis is also supported in the comment by Dr. Rizkalla.

In summary, I find that the limited biopsy evidence available neither precludes nor establishes the presence of pneumonoconiosis. The comments of Drs. Perper and Rizkalla suggest, however, that had a biopsy been performed involving the upper lobes of the lungs, that coal workers' pneumoconiosis may have been established (Perper) or been more extensive (Rizkalla). However, in the absence of such a biopsy and/or an autopsy, I find that the Claimant has failed to meet her burden of establishing pneumoconiosis under §718.202(a)(2).

Finally, although the foregoing biopsy evidence is new, it does not establish grounds for modification in the miner's claim, because it does not demonstrate a change in condition or a mistake in fact. (DX 56, p. 4).

C. Pulmonary Function Studies

As outlined in Employer's Pre-Hearing Report and confirmed by the record, the case file contains pulmonary function evidence which covers the period from August 16, 1977 through March 23, 1998 (ALJX 1, pp. 17-18). Based upon the miner's found height of 72.5 inches and age at the time of testing, I find that, although the early tests were not qualifying, the overwhelming preponderance of the more recent pulmonary function studies are qualifying under the applicable regulatory standards set forth in Part 718, Appendix B. Accordingly, I find that, taken as a whole, the pulmonary function evidence supports a finding of total disability under § 718.204(b)(1)(2)(i). Moreover, the Employer does not contest the total disability issue (TR 20).

Regarding Employer's modification request in the miner's claim, I note that the foregoing determination is also consistent with Judge Neusner's Decision and Order on Remand - Awarding Benefits (DX 56, pp. 5-6).

D. Arterial Blood Gas Studies

As set forth in Employer's Pre-Hearing Report and confirmed by the record, the case file contains arterial blood gas studies which cover the period from June 5, 1979 through February 23, 1998 (ALJX 1, pp. 19-20). The results of the older studies were either not readable, non- qualifying under the applicable standards set forth in Part 718, Appendix C, or of questionable validity. However, the clear preponderance of the arterial blood gas studies since May 5, 1994, including the most recent, are qualifying. Therefore, taken as a whole, I find that the arterial blood gas evidence also supports a finding of total disability under §718.204(b)(1)(2)(ii). As previously stated, the Employer does not contest the total disability issue (TR 20).

Regarding Employer's modification request in the miner's claim, I again note that the foregoing determination is consistent with Judge Neusner's Decision and Order on Remand - Awarding Benefits (DX 56, p. 6).

E. Physicians' Opinions (Non-Pathology) and Other Medical Evidence

The pre-modification request (non-pathology) medical opinions, which are summarized in the Employer's Pre-Hearing Report (ALJX 1), include: multiple findings by the Occupational Pneumoconiosis Board in 1976, 1977, 1988, and 1992 (DX 10,20); and the (pre-modification request) reports and/or depositions of Drs. Hendrick (DX 20, 89), Cox (DX 20,89), Piccirilo (DX 2088), Bellotte (DX 20,88,41,47), Wiot (DX 47), Loudon (DX 20,47), Hippensteel (DX 20,45), Devanbhaktuni (DX 15,20,40), Renn (DX 30A,53), Rasmussen (DX 20,48,46), and Morgan (DX 20,43).

In summary, the Occupational Pneumoconiosis Board consistently found the presence of occupational pneumoconiosis. Furthermore, during the period from 1976 to 1992, the pulmonary functional impairment attributable to the disease increased from 15% to 50%. In 1977, Dr. Hendrick failed to find any evidence of lung disease or respiratory impairment. In 1979, Dr. Cox diagnosed pneumoconiosis and emphysema related coal mine dust exposure. In 1980, Dr. Piccirillo found insufficient objective evidence to diagnose coal worker's pneumoconiosis. Furthermore, he did not find any significant pulmonary impairment. Dr. Bellotte's findings in 1989 and 1995 are inconsistent. In 1989, Dr. Bellotte found evidence of the disease, whereas in 1995, he found insufficient evidence to make the diagnosis. However, Dr. Bellotte clearly found the miner totally disabled by his pulmonary condition, albeit due to cigarette smoking, not coal dust exposure. Dr. Wiot found no evidence of pneumoconiosis primarily based upon his analysis of the available x-ray evidence. In 1995 reports, Drs. Loudon and Hippensteel, respectively, both found that the miner was totally disabled by a pulmonary or respiratory impairment caused by cigarette smoking; however, they stated that there was insufficient objective evidence to justify a diagnosis of pneumoconiosis; and, even if the miner had the disease, it did not contribute to the miner's disability. Dr. Devanbhaktuni has consistently found that the miner suffered from coal worker's pneumoconiosis and severe pulmonary impairment related to

cigarette smoking and occupational dust exposure. Dr. Renn has repeatedly found that the miner is totally disabled by his severe obstructive ventilatory defect. However, he related the miner's condition to cigarette smoking, and excluded pneumoconiosis and/or coal mine dust exposure as a contributing cause. In 1995, Dr. Rasmussen has consistently diagnosed "Legal Pneumoconiosis" and found that the miner's coal mine dust exposure was a significant contributing factor, together with his cigarette smoking history, in causing the miner's disabling respiratory impairment. Finally, in 1995, Dr. Morgan opined that there was no objective evidence of CWP, and that the miner's significant respiratory impairment was not related to his coal mine employment.

The foregoing evidence was before Administrative Law Judge Neusner and the Benefits Review Board (DX 54,55,56; ALJX 2). Based upon my own independent review of the (pre-modification request) evidence, I adopt and incorporate by reference Judge Neusner's analysis of the medical opinion evidence, as affirmed by the Benefits Review Board, in its Decision and Order, dated May 22, 1998 (ALJX 2). In particular, I find that the (pre-modification request) opinions of Drs. Devanbhaktuni and Rasmussen are most persuasive and probative because those opinions are most consistent with the miner's complaints of breathing problems, his 37 year history of coal mine dust exposure, his abnormal pulmonary function studies both before and after bronchodilator, and his abnormal arterial blood gas tests. Moreover, I find that the opinions of Drs. Renn, Bellotte, Morgan, and Hippensteel are undermined by their reliance, at least in part, upon inaccurate information regarding the duration and extent of Mr. Earl's coal dust exposure.
Accordingly, I also find that the medical opinion evidence previously presented establishes pneumoconiosis under §718.202(a)(4). Furthermore, the credible medical evidence supports, rather than rebuts, the presumption that the disease arose from his more than ten years from coal mine employment under §718.203. In addition, such evidence establishes that pneumoconiosis significantly contributed to the miner's total disability.

The case file contains the additional medical reports and/or depositions of various non-pathologists, such as Drs. Stillings (CX 1), Manchin (CX 2), Dedhia (DX 20), Gaziano (DX 20, 79,80), Devanbhaktuni (DX 51), Morgan (DX 50,72,73; EX 4), Hippensteel (DX 50,71), Renn

(EX 1,3,6), and Rasmussen (CX 4); the miner's death certificate (DX 20); and the opinions of Drs. Kleinerman (DX 50,69,72,73) and Rizkalla (CX 3), pathologists who, as stated above, also analyzed non-pathology evidence in discussing issues relevant to the miner's and widow's claims.

Dr. Samuel L. Stillings issued a report dated February 22, 1995 (CX 1). Accordingly, the report pre-dated the decisions by Judge Neusner and the Benefits Review Board. In his report, Dr. Stillings stated that he had treated the miner since 1955. Dr. Stillings also cited the miner's long history of coal mine employment and "long progressive history of pulmonary problems." Based upon the foregoing, Dr. Stillings concluded that the miner developed pneumoconiosis and total disability, which are related to Mr. Earl's employment in the mining industry. In addition, Dr. Stillings opined that the miner's immunity system was affected and resistance is subpar. Furthermore, Dr. Stillings cited the

miner's "repeated attacks of Tracho Bronchitis, Sinusitis, and Emphysema" and concluded that the miner is disabled therefrom. He also noted that the miner's condition had worsened over the prior 12 to 15 years (CX 1).

Dr. John Manchin II, D.O., issued a report dated February 20, 1995 (*i.e.*, pre-dating the administrative law judge and Board decisions). Dr. Manchin stated that he evaluated the miner on February 8, 1995 for occupational lung disease. He cited a fairly accurate coal mine employment history of 42 years; the State and Federal awards of black lung benefits; abnormalities on physical examination of the lungs; and, chest x-ray and pulmonary function testing consistent with occupational pneumoconiosis. Based upon the foregoing, Dr. Manchin diagnosed occupational pneumoconiosis and sought favorable consideration for the miner's claim (CX 2).

Dr. Marie Ann Stemple, a Resident in Medicine, signed Mr. Earl's "Death Summary," dated May 14, 1998, for Dr. Harakh V. Dedhia, the "Responsible Staff Physician" and "Professor, Department of Medicine" at West Virginia University Hospital (DX 20). Furthermore, the case file indicates that Dr. Dedhia was a treating physician of the miner during the latter's final hospitalization before death. The preliminary information on the report misstates the admission date as "01/01/01," and lists the date of death as "5/14/98" instead of 5/13/98. The latter mistake is corrected in the substantive portion of the report. The full text of the report is as follows:

> DEATH SUMMARY: The patient is a 65-year-old white male who was admitted to cardiothoracic surgery for surgical resection of his lung carcinoma. Following the surgery, the patient was able to be extubated; however, he developed severe respiratory distress and subsequently had to be reintubated. Throughout his hospital course, his respiratory status continued to decline. He developed multiple episodes of pneumonia. Throughout his stay, he continued to decline from a respiratory status and when it became apparent that he was not going to be able to extubated, he and his family had extensive discussion with both Dr. Graeber and Dr. Dedhia, and the patient felt that he did not want to spend the rest of his life on the ventilator and at that point he demanded cessation of treatment. The patient expired approximately thirty-five minutes after life support was stopped. He was pronounced dead by me at 1:35 p.m. on May 13, 1998. (Emphasis in original). His
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> family was present at his side. Cause of death was respiratory arrest secondary to respiratory failure as a consequence of his severe chronic obstructive pulmonary disease, emphysema and black lung.

(DX 20).

Dr. D. Gaziano, a medical consultant for the Department of Labor, provided cursory and conflicting opinions in response to questions posed and somewhat limited evidence provided by a

claims examiner on September 21, 1998 (DX 20,81), June 1, 2000 (DX 79), and July 18, 2000 (DX 80), respectively.

In September 1998, Dr. Gaziano answered "Yes" to a question indicating that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death. The rationale for this opinion was as follows: "The claimant (Earl Willard) died a respiratory death, had established antemortem diagnoses of COPD and CWP. It is my opinion that CWP was a significant contributing factor in his death." (DX 80).

In June 2000, Dr. Gaziano stated: "I gave an opinion on 09/30/98 based on antemortem clinical criteria and 39 yrs. of coal mine employment history that Mr. Earl had CWP and which contributed to his demise. The medical evidence now submitted to me includes a pathological evaluation of resected lung tissue by Dr. Kleinerman and Dr. Barcea - neither of whom found traces of CWP. The path report from WVU Hosp. was not provided and would have been helpful. If the consensus of reliable pathological authority is that there was no CWP present, then I do not think CWP would have been a significant contributing factor in his demise. However, if available the pathological report from WVU Hosp. Would be helpful and I would be happy to review it for you before giving a final opinion." (DX 79).

In July 2000, Dr. Gaziano stated: "I reviewed the path report from WVU Hosp. No mention of CWP is made or found. It appears from the preponderance of evidence that CWP was not present (and, therefore, CWP) would not have contributed to disability or to the claimant's (Mr. Earl's) demise (DX 81).

Dr. Prasad V. Devanbhaktuni, who is Board-certified in Internal Medicine and Pulmonary Disease, had issued a report in 1994 (DX 15,20), and testified at deposition on March 27, 1995 (DX 40). He found that the miner had pneumoconiosis, as defined in the Act, and that the disease contributed to the miner's totally disabling respiratory or pulmonary impairment. This finding was credited, together with Dr. Rasmussen's, by Judge Neusner and affirmed by the Benefits Review Board. Furthermore, it is consistent with my own independent analysis of the evidence presented prior to the modification request. Since Dr. Devanbhaktuni's earlier opinion pre-dated the miner's death, he obviously did not address the "death due to pneumoconiosis" issue in his earlier findings. As stated above, Dr. Devanbhaktuni also reported the results of a bronchoscopy in February and March 1998. The pathology reports did not make a specific finding of medical pneumoconiosis. Dr. Devanbhaktuni's most recent analysis is contained in his testimony at

deposition held on March 11, 1999, which was taken by Employer, but subject to cross-examination by Claimant's former counsel (DX 51).

At deposition in March 1999, Dr. Devanbhaktuni cited some clinical test results, such as pulmonary function tests, chest x-rays, CT scans and pathology findings. However, his testimony was

somewhat ambiguous and contradictory. For example, Dr. Devanbhaktuni stated that "coal dust exposure can cause obstructive impairment, but not coal worker's pneumoconiosis." (DX 51, Deposition, p. 34). Furthermore, it was Dr. Devanbhaktuni's understanding that the miner's death was caused by complications from surgery, such as postoperative GI bleeding (DX 51, Deposition, p. 27). On the other hand, Dr. Devanbhaktuni reiterated that the miner's coal dust exposure combined with cigarette smoking to cause COPD, but stated that the coal dust exposure alone would not cause a disabling impairment (DX 51, Deposition, pp. 17,37-38).

Dr. W.K.C. Morgan, a B-reader and Board-certified (British) pulmonologist (EX 5) had previously opined that the miner had failed to establish pneumoconiosis and/or total disability therefrom. His opinion was deemed unpersuasive by Judge Neusner, as affirmed by the Benefits Review Board. As outlined above, based upon my own independent analysis of the evidence presented prior to the modification request, I also accord it less weight. More recently, Dr. Morgan issued a report, dated July 1, 1999 (DX 50,72), testified at deposition held on July 23, 1999 (DX 50,73), and issued a supplemental report, dated July 8, 2001 (EX 4).

Dr. Morgan continues to find that the evidence is insufficient to make a diagnosis of coal worker's pneumoconiosis. In making this determination, Dr. Morgan acknowledges the presence of a severe pulmonary impairment, but he relates it entirely to cigarette smoking, not coal mine dust exposure. In so finding, Dr. Morgan cited with approval Dr. Kleinerman's pathology findings, while criticizing the conclusions of Drs. Rasmussen and Rizkalla, as well as their reliance on cited medical literature. In his final report, Dr. Morgan concluded:

> **SUMMARY**
>
> I have little to add to my prior report of August 25, 1995. Suffice it to say that I find neither Dr. Rasmussen nor Dr. Rizkalla's reports to be in any way convincing. Dr. Rizkalla describes macules and implies they are associated with impairment. This is not the case and is made quite clear in the Pathology Standards to which Dr. Rizkalla refers. When macules only are present there is no evidence of airways obstruction. Further statements to this effect are to be found in Occupational Lung Disease by Churg and Green. Furthermore, as far as I am concerned, the x-rays have not shown any radiographic evidence of CWP in the late Mr. Earl. In addition, his former job did not involve heavy exposure to coal mine dust, nor to silica since no mention is made of silicotic nodules only the presence of some doubly refractible material which need not necessarily be silica and could easily be silicates.

(EX 4).

Dr. Kirk E. Hippensteel, a B-reader and Board-certified pulmonologist, had previously concluded that the miner did not establish pneumoconiosis or total disability therefrom. However, his opinion was accorded less weight by Judge Neusner, as affirmed by the Benefits Review Board, and is consistent with my own independent analysis of the evidence presented prior to the modification request. In his more recent report, dated July 8, 1999 (DX 50,71), Dr. Hippensteel reviewed various additional medical data. In conclusion, Dr. Hippensteel stated:

> These additional medical records, I think, support the conclusions reached in my previous review of records in his case, and go against the opinions noted by Dr. Rasmussen in this case. This man showed evidence of bullous emphysema and partially reversible obstructive airways disease that are not features of coal workers' pneumoconiosis but are associated with long-term cigarette smoking which this man had. In addition, his lung cancer with his prolonged illness post lung cancer resection, was also related to his cigarette smoking and not his coal dust exposure. This man had chronic basilar interstitial markings that turned into pneumonia and made markings more prominent post operatively. These markings were not found to be related to coal workers' pneumoconiosis pathologically but were likely initially secondary to some relaxation ateclectasis and chronic bronchitis associated with his bullous emphysema and cigarette smoking. The fact that these problems worsened while he continued to smoke long after leaving work in the mines, is also an additional factor showing that his smoking rather than coal workers' pneumoconiosis was the cause from his pulmonary impairment. Dr. Rasmussen's statement that the x-ray is a poor indicator of coal workers' pneumoconiosis was proven to be false in this particular case by the fact that many expert readers who thought no coal workers' pneumoconiosis was present on his x-rays were found to be correctly interpreting these films since there is no evidence of coal workers' pneumoconiosis pathologically either. The additional findings discussed by Dr. Kleinerman corroborates the opinions reached in my prior review of records and additionally in these records, with a reasonable degree of medical certainty. The evidence in this case shows that this man died terminally of illness secondary to lung cancer requiring lung resection with postoperative complications including prolonged lung infections with the development of adult respiratory distress syndrome by x-ray and chronic respiratory failure that led to his death. There is a lack of evidence in this case that this man had impairment whatsoever from his prior coal dust exposure. There is strong and substantial evidence that this man's impairment related to bullous emphysema which is at least partly congenital and added to otherwise by his chronic cigarette smoking habit which produced partially reversible obstructive airways disease and lung cancer, leading to further complications that led to his death. The records show with a reasonable degree of medical certainty that this man would have died of the same problems at the same time had he never set foot in a coal mine.

(DX 71).

Dr. Joseph J. Renn, a B-reader and Board-certified pulmonologist (EX 2), had previously stated that the miner did not have pneumoconiosis and that the miner's total disability is unrelated to pneumoconiosis or coal mine dust exposure. As set forth above, this opinion was found unpersuasive by Judge Neusner, as affirmed by the Benefits Review Board. Furthermore, it was accorded less weight based upon my own independent analysis of the evidence presented prior to the modification request.

Dr. Renn issued a supplemental report, dated June 12, 2001 (EX 1), in which he reviewed various medical data, and set forth the miner's history, as well as some reported findings on physical examination, and laboratory data. Dr. Renn did not modify his prior analysis of the miner's occupational and tobacco histories. In summary, Dr. Renn stated:

DIAGNOSES:

I RESPIRATORY SYSTEM

1. Progressive respiratory failure owing to multiple pulmonary insults superimposed upon
2. bullous, centrilobular, and panacinar emphysema owing to tobacco smoking and
3. chronic bronchitis owing to tobacco smoking.
4. Recurrent nosocomial pneumonias.
5. Pulmonary emboli.
6. Status post left lower lobectomy for squamous cell carcinoma and adenosquamous cell carcinoma of the lung owing to tobacco smoking.
7. A pneumoconiosis did not exist.
8. Severe, significantly bronchoreversible obstructive ventilatory defect owing to tobacco smoking.

II. CARDIOVASCULAR SYSTEM

1. Systemic hypertension.

It is with a reasonable degree of medical certainty that none of the above diagnoses were either caused, or contributed to, by either Mr. Willard Earl's exposure to coal mine dust or coal worker's pneumoconiosis. It is with a reasonable degree of medical certainty that Mr. Willard Earl did not have coal workers' pneumoconiosis. It is with a reasonable degree of medical certainty that he was totally and permanently impaired to the extent that he would have been unable to perform any of his last coal mining jobs or any similar work effort. It is with a reasonable degree of medical certainty that coal workers' pneumoconiosis neither caused, nor

> contributed to, his demise. It is with a reasonable degree of medical certainty that his demise would have occurred when, and in what manner, it would have whether or not he had ever been exposed to coal mine dust.

(EX 1).

Dr. Renn reiterated the foregoing opinion in his testimony at deposition on June 21, 2001, stating that the miner's totally disabling pulmonary impairment was due to tobacco smoking and resulting bullous emphysema, not chronic coal mine dust-induced lung disease. Furthermore, Dr. Renn stated that the miner's death was not hastened or caused by chronic coal mine dust-induced lung disease (EX 3, p.25). In reaching this conclusion, Dr. Renn cited the miner's 40-pack smoking history; x-ray, CT scan, and pathology evidence which were interpreted as negative for pneumoconiosis; "significant bronchoreversibility" on pulmonary function testing; and, arterial blood gases which were "relatively low (in) oxygen for his age, even at rest, but, then, when he tried to exercise, it became much worse." (EX 3, pp. 5-25). In his deposition testimony, Dr. Renn stated that, despite the fact that the miner primarily worked above ground, he did not rule out the likelihood that Mr. Earl would develop a chronic coal mine dust-induced lung disease, "because there are aboveground workers who do develop coal workers' pneumoconiosis...It occurs with less frequency; but still, it occurs." (EX 3, p.15). However, Dr. Renn never specifically corrected his previously stated misperception regarding the extent and duration of the miner's actual coal mine dust exposure, nor did he adequately explain his previous comments regarding the "inert" nature of the coal mine dust which the miner breathed (DX 54, pp. 5-7). In a rather cursory report, dated August 10, 2001, Dr. Renn noted that he had reviewed reports by Drs. Rasmussen and Rizkalla, but that their findings did not alter his opinion (EX 6).

Dr. D.L. Rasmussen, who is Board-certified in Internal Medicine and Forensic Medicine, and practices at the Appalachian Regional Healthcare Division of Pulmonary Medicine (CX 4), had previously found that the miner had pneumoconiosis, as defined in the Act, and that the disease contributed to the miner's totally disabling respiratory or pulmonary impairment. This finding was credited, together with Dr. Devanbhaktuni's, by Judge Neusner and affirmed by the Benefits Review Board. Furthermore, it is consistent with my own independent analysis of the evidence presented prior to the modification request. Since Dr. Rasmussen's earlier opinion pre-dated the miner's death, it did not address the "death due to pneumoconiosis" issue in his earlier findings.

In his most recent report, dated November 9, 2000 (CX 4), Dr. Rasmussen reviewed various additional medical evidence. Furthermore, Dr. Rasmussen reported a fairly accurate history of "significant history of exposure to coal mine dust" in 40+ years of coal mine employment "primarily in surface mining;" a "significant history of cigarette smoking;" Mr. Earl's complaints of progressive shortness of breath beginning in 1980; significant pulmonary function abnormalities which began to manifest itself in 1988 and 1989 and progressed through the years; a history of thoracotomy in 1998; and, biopsy findings by Dr. Kleinerman. Furthermore, Dr.

Rasmussen cited various medical literature particularly regarding the relationship between interstitial fibrosis and coal miners. Based upon the foregoing, Dr. Rasmussen concluded:

> In spite of the fact that Dr. Kleinerman was an expert in occupational pulmonary pathology, it is my opinion that Mr. Earl suffered from a totally disabling, ultimately fatal chronic respiratory disease which was the consequence not only of his cigarette smoking, but also his occupational dust exposure in the coal mining industry.

(CX 4).

The miner's death certificate, which was signed by Dr. Marie A. Stemple, states that Mr. Earl died on May 13, 1998, at age 65, of respiratory arrest due to respiratory failure, emphysema and black lung (DX 20).

As stated above, Drs. Kleinerman (DX 50,69,72,73) and Rizkalla (CX 3) are pathologists who also analyzed non-pathology evidence and addressed the issues of pneumoconiosis and causation regarding the miner's and widow's claims.

Dr. Jerome Kleinerman, a Board-certified pathologist with numerous publications to his credit, issued a report, dated April 28, 1999 (DX 50,69). Dr. Kleinerman reported the following: a fairly accurate coal mine employment history of 39 years ending in 1991; a 40+ pack year cigarette smoking history which reportedly ended in 1987; Dr. Renn's finding in 1994 of a carboxyhemoglobin level indicative of a current user of combustible tobacco products; various medical opinions and clinical test results reported in 1977, 1979, 1988, 1989, 1990, 1994, 1995, and 1998. In addition, Dr. Kleinerman made his own review of the biopsy slides, which showed "No evidence of simple CWP, no evidence of simple silicosis, and no evidence of complicated pneumoconiosis." Based upon the foregoing, Dr. Kleinerman opined that Mr. Earl did not have pneumoconiosis; that Mr. Earl's obstructive lung dysfunction and reduced capacity to perform coal mine work did not result from CWP or simple silicosis; that coal mine dust exposure or CWP had no significant effect on the miner's death; that the miner's primary lung cancer was not caused by coal mine dust or CWP, but rather cigarette smoking ; and, Mr. Earl's severe obstructive lung dysfunction and his primary lung cancer were caused by prolonged and heavy cigarette smoking. In so finding, Dr. Kleinerman cited the Report of the U.S. Surgeon General on Smoking and Health (1964), which documented that cigarette smoking is the most common cause of primary lung cancer, chronic obstructive lung dysfunction, chronic bronchitis, centracinar and paniacinar emphysema, severe coronary artery atherosclerosis, and myocardial infarction, in those people with cigarette smoking of 20 pack years or more (DX 50,69).

Dr. Kleinerman reiterated the foregoing opinion in his testimony at deposition held on June 29, 1999 (DX 72, pp. 42-43). On cross-examination, Dr. Kleinerman acknowledged that it is possible that the miner had simple coal workers' pneumoconiosis even though it was not evident on the lung tissue which he examined, because it is more common in the upper lobes.

However, Dr. Kleinerman stated that based upon a 39-year coal mine employment history, he would have expected the condition to be sufficiently diffuse to be present in the lower lobes, and he didn't see it (DX 72, pp. 42-43).

Dr. Waheeb Rizkalla, an Associate in Pathology, issued a pathology report dated January 16, 2001 (CX 3). As outlined above, Dr. Rizkalla's final anatomic diagnoses included: squamous cell carcinoma of the left lower lung lobe; bullous emphysema with scar emphysema; interstitial pulmonary fibrosis; and simple coal workers' pneumoconiosis. Furthermore, he noted on the pathology report that coal dust tends to affect the upper lung lobes. Therefore, the available pathology evidence may not be truly representative of the degree of coal workers' pneumoconiosis present. In addition to the pathology report, Dr. Rizkalla issued a separate report, dated January 16, 2001, in which he addressed various questions posed by Claimant's lay representative. Citing medical records, the pathology slides, the miner's clinical history, and medical literature, Dr. Rizkalla concluded that Mr Earl had coal worker's pneumoconiosis and that pneumoconiosis was a substantial factor in hastening the miner's death. In conclusion, Dr. Rizkalla stated:

> To summarize, the severe bullous emphysema that the deceased developed was not solely induced by smoking, but according to the literature, coal dust exposure also played a role in its development. I believe that coal workers' pneumoconiosis, through inducing the severe emphysema present and impairing the lung function of the deceased, was a substantial contributing factor in excellerating (sic) his death after his cancer surgery (keeping in mind that his malignancy was limited to the left lower lobe with no evidence of local or distant metastases).

(CX 3).

Discussion and Analysis

Miner's Claim

Modification Under 20 C.F.R. §725.310

In a modification case involving a living miner's claim, the threshold issue is whether the Claimant has established a change in condition or mistake in a determination of fact, as provided in § 725.310. Accordingly, I must "perform an independent assessment of the newly submitted evidence, in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement in the prior decision." *Napier v. Director, OWCP*, 17 BLR 1-111 (1993). As discussed herein, all of the evidence has been considered and weighed.

As set forth above, Judge Neusner found that the (pre-modification request) evidence established that the miner had pneumoconiosis which arose out of his 37 years of coal mine employment; and, that the disease contributed to the miner's totally disabling impairment. In so finding, Judge Neusner did not rely on x-ray or biopsy evidence, but rather qualifying pulmonary function studies, abnormal arterial blood studies, and, in particular, the credible medical opinion evidence of Drs. Rasmussen and Devanbhaktuni, which he credited over the opinions of Drs. Renn, Bellote, Morgan and Hippensteel. The foregoing was affirmed by the Benefits Review Board. Furthermore, as discussed above, based upon my independent analysis of such evidence, I also find that the miner did establish entitlement on the basis of the previously considered evidence.

As outlined above, the newly submitted evidence includes additional x-ray and CT scan interpretations, biopsy evidence, pulmonary function studies, arterial blood gas tests, and various medical opinions. Since the Employer concedes the total disability issue (TR 20), the underlying issues are: pneumoconiosis, causal relationship, and causation.

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence. Having considered all of the x-ray evidence, old and new, I find that it is still inconclusive. Although the majority of interpretations are either negative for pneumoconiosis or fail to meet the classification requirements of §718.102(b), there are several positive findings for pneumoconiosis by other well-credentialed B-readers and/or Board-certified radiologists. Therefore, I find that the x-ray evidence neither precludes nor establishes the presence of pneumoconiosis. Accordingly, the Claimant has failed to meet her burden of establishing pneumoconiosis under §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. Prior to Employer's modification request the record did not contain any such evidence. Therefore, pneumoconiosis obviously could not be established on that basis. Although there is no autopsy evidence, the record now includes several biopsy reports. As discussed herein, I find the newly submitted biopsy evidence inconclusive. Again, a majority of the pathologists did not specifically diagnose pneumoconiosis. However, not only did Dr. Rizkalla diagnose the disease, but also, Drs. Garcia and Perper each mentioned the presence of some "anthracosis" which meets the definition of pneumoconiosis under §718.202(a)(1). Yet these same pathologists, as well as others, such as Dr. Kleinerman, stated that the biopsy evidence did not warrant a diagnosis of pneumoconiosis. Therefore, I find that the biopsy evidence is also inconclusive. Moreover, even if the biopsy were clearly found to be negative for pneumoconiosis, it would not be dispositive of the issue. As outlined above, various pathologists agree, and I find, that coal workers' pneumoconiosis usually presents itself primarily in the upper lung lobes. Accordingly, a biopsy of the lower lobe of the left lung which does not conclusively establish pneumoconiosis, does not rule out the possibility that the disease is present elsewhere in the

lungs. Furthermore, even if the miner did not establish the presence of medical pneumoconiosis, it does not preclude a finding of legal pneumoconiosis, as defined in §718.202(a)(2). Nevertheless, taken as a whole, I find that the Claimant has failed to meet her burden of establishing pneumoconiosis under §718.202(a)(2).

Since the presumptions described in §§718.304, 718.305, and 718.306 are not applicable, pneumoconiosis cannot be established pursuant to §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffered from pneumoconiosis as defined in §718.2021. This includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment.

As summarized above, the earlier medical opinion evidence, in particular, those of Drs. Rasmussen and Devanbhaktuni, established the existence of pneumoconiosis under this subsection. Moreover, their opinions have expressly been found to be more credible than the earlier opinions of Drs. Renn, Bellote, Morgan and Hippensteel.

Except for Dr. Bellote, whose prior opinion was conflicting and discredited, the above-name physicians have all issued submitted newly medical reports and/or testified at deposition. Drs. Renn, Morgan and Hippensteel all reiterated their prior conclusions; namely, that the miner did not have coal worker's pneumoconiosis and that his total disability is unrelated to coal mine dust exposure. Dr. Rasmussen also maintained his prior opinion and reiterated that the miner's totally disabling respiratory impairment is due to a combination of coal mine dust exposure and cigarette smoking. As stated above, Dr. Devanbhaktuni's newly expressed opinion is ambiguous and confusing. This somewhat undermines Dr. Devanbhaktuni's prior medical opinion, in which he concurred with Dr. Rasmussen's analysis.

As outlined above, the case file also contains the medical reports and/or depositions of Drs. Stillings (CX 1), Manchin (CX 2), Dedhia (DX 20), Gaziano (DX 20, 79,80), Kleinerman (DX 50,69,72,73) and Rizkalla (CX 3).

Of the foregoing, Dr. Kleinerman, a pathologist, consistently stated that the evidence was insufficient to establish coal worker's pneumoconiosis. Dr. Gaziano's statements were cursory and

conflicting. On the other hand, the opinions of Drs. Stillings, Manchin, Dedhia, and Rizkalla buttress Dr. Rasmussen's opinion, as did the Death Summary and Death Certificate signed by Dr. Stemple.[4]

Despite the impressive credentials of Drs. Renn, Morgan, Hippensteel, and Kleinerman, I find the opinion of Dr. Rasmussen to be most persuasive. As fact-finder, I having carefully considered all of the evidence presented, and I have determined that Dr. Rasmussen's opinion is most consistent with the miner's complaints of worsening breathing problems; the miner's extensive smoking and coal mine employment histories; the actual extent and duration of the miner's exposure to coal mine dust; the abnormal arterial blood gas test results; and qualifying pulmonary function studies before and after bronchodilator. Several of the physicians cited by Employer relied, at least in part, upon "negative" x-ray and biopsy evidence. However, as previously stated, the foregoing evidence was inconclusive. It certainly did not rule out "Legal Pneumoconiosis." Furthermore, those same physicians cited the "partial reversibility" shown on pulmonary function testing, as inconsistent with pneumoconiosis, because that disease is progressive and irreversible. However, the post-bronchodilator pulmonary function results were still grossly abnormal, which is consistent with Dr. Rasmussen's conclusion that the miner's total disability (and death) were attributable to a combination of cigarette smoking and occupational dust exposure. In view of the foregoing, I find that the Claimant has established the presence of pneumoconiosis under §718.202(a)(4).

Since Mr. Earl's last coal mine employment occurred in West Virginia (DX 4), this case is governed by the holdings of the U.S. Court of Appeals for the Fourth Circuit. In *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. §718.202(a) to determine whether the miner suffered from coal worker's pneumoconiosis. *See also, Penn Allegheny Coal Co. v. Williams*, 114 F. 3d 22, 24-25 (3d Cir. 1997). Although the x-ray and biopsy evidence is inconclusive regarding the presence of pneumoconiosis, the better reasoned medical opinion evidence, in particular Dr. Rasmussen's opinion, establishes the presence of "legal pneumoconiosis" under §718.202(a)(2).

Causal Relationship

Since the Claimant has established the existence of pneumoconiosis, she is entitled to the rebuttable presumption that the disease arose from the miner's more than ten years of coal mine employment. *See* 20 C.F.R. §718.203 and §718.302. In the absence of any credible evidence to the contrary, I find that this presumption has not been rebutted.

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[4]Dr. Stillings' opinion is accorded somewhat less weight because he did not refer to any specific clinical test results; however, he reported that he had been the miner's treating physician since 1955, and cited the miner's long history of pulmonary problems and coal mine employment.

Total Disability

The Employer stipulated, and I find, that the miner suffered from a total respiratory disability (TR 20). This is clearly borne out by the clinical test results and the medical opinion evidence (ALJX 1).

Total Disability Due to Pneumoconiosis

Under the provisions of §718.204(c)(1), "a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in §718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment" (*i.e.*, pneumoconiosis had a material adverse effect on the miner's respiratory or pulmonary condition; or, it materially worsened a totally disabling respiratory or pulmonary condition which was caused by a disease or exposure unrelated to coal mine employment). Furthermore, the cause or causes of the Claimant's total disability shall be established by means of a documented and reasoned physician's opinion. *See* amended 20 C.F.R. §718.204(c)(2).

For the reasons previously stated, I find that the miner suffered from "legal pneumoconiosis," and that the disease was a substantially contributing cause of his total respiratory disability. Accordingly, I find that the miner was totally disabled due to pneumoconiosis within the meaning of the Act and applicable regulations. Therefore, taken as a whole, I find that the Employer has failed to establish a basis for his modification request under §725.310.

Widow's Claim

For the reasons set forth above, I find that the Claimant has established that the miner suffered from pneumoconiosis which arose from his coal mine work. However, in order to be eligible for survivor's benefits, the Claimant must also establish that the miner's death was due to pneumoconiosis, as defined in the Act and regulations.

Death due to Pneumoconiosis

Since the widow's claim was filed after January 1, 1982, the issue of death due to pneumoconiosis is governed by §718.205(c), as amended, which states, in pertinent part:

> For the purpose of adjudicating survivor's claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:

(1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or

(2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or

(3) Where the presumption set forth at §718.304 is applicable.

(4) However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.

(5) Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death.

20 C.F.R. §718.205(c).

As outlined herein, the "death due to pneumoconiosis" issue was specifically addressed in the miner's death certificate; and in the medical reports and/or depositions of Drs. Stemple/Dedhia, Devanbhaktuni, Perper, Gaziano, Morgan, Hippensteel, Renn, Rasmussen, Kleinerman, and Rizkalla.

Almost all of the physicians agreed that the miner died a respiratory death. The possible exception appears to be Dr. Devanbhaktuni, who suggested that the miner's death was due to post-operative complications, such as G.I. bleeding (DX 51, p. 27). As previously stated, Dr. Devanbhaktuni's testimony was ambiguous and appears to, at least partially, contradict his prior reports regarding the role of coal mine dust exposure in the miner's total respiratory disability. Therefore, I accord it little weight. In addition, Dr. Perper did not diagnose pneumoconiosis, nor did he relate the disease to the miner's death. However, Dr. Perper's opinion is undermined by his statement that he could not reliably determine the cause of the miner's death, based solely on the reviewed microscopic findings of the miner's resected lung and biopsy report. Furthermore, I accord little weight the cursory and conflicting medical opinions set forth by Dr. Gaziano.

Of the remaining physicians who address the "death due to pneumoconiosis" issue, Drs. Morgan, Hippensteel, Renn, and Kleinerman concluded that the miner's coal mine dust exposure did not cause, contribute to, or hasten the miner's death. However, their opinions are undermined by their failure to even diagnose pneumoconiosis and/or any respiratory impairment due to coal mine dust exposure. Accordingly, I find their opinions are less persuasive than the other relevant medical opinion

evidence, including the miner's death certificate, the death summary authored by Dr. Stemple on behalf of Dr. Dedhia, and the opinions of Drs. Rasmussen and Rizkalla.

As summarized above, the death certificate, signed by Dr. Stemple, clearly states that the miner died of respiratory arrest due to respiratory failure, emphysema, and black lung. It is well established, however, that, absent other credible evidence, a death certificate alone is insufficient to establish death due to pneumoconiosis. *Addison v. Director, OWCP*, 11 BLR 1-68 (1988) (where a death certificate, in and of itself, was found to be unreliable, since the record did not provide any indication that the individual who signed it possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death). *See also, Lango v. Director, OWCP*, 104 F.3d 573 (3d Cir. 1997) (where the court reiterated that a treating physician's opinion may be accorded greater weight but found it permissible for the administrative law judge to require more than a conclusory statement before finding that pneumoconiosis contributed to the miner's death, and adopted the holding of the Eighth Circuit in *Risher v. Office of Workers' Compensation Programs*, 940 F.2d 327, 331 (8th Cir. 1991), that "the mere fact that a death certificate refers to pneumoconiosis cannot be viewed as a reasoned medical finding,

particularly if no autopsy has been performed".) *Cf., Dillon v. Peabody Coal Co.*, 11 BLR 1-113 (1988) (where a physician's opinion expressed on a death certificate together with his testimony was sufficient to establish the cause of death).

In the present case, I find that the death certificate is supported by other evidence, and we clearly know the relationship between the signer of the death certificate, Dr. Stemple, and the deceased miner. Dr. Stemple, a Medical Resident, was the miner's treating physician, in conjunction with Dr. Dedhia on the day the miner died. In fact, Dr. Stemple signed the Death Summary on behalf of Dr. Dedhia, and reported the circumstances which immediately preceded the miner's death. Moreover, the Death Summary also lists black lung among the underlying causes of the miner's death.

In addition, the report of Dr. Rasmussen supports the finding of death due to pneumoconiosis under the regulations. Although Dr. Rasmussen's analysis regarding the "death due to pneumoconiosis" issue could have been somewhat more detailed, he clearly related the miner's "ultimately fatal chronic respiratory disease" to the combination of cigarette smoking and occupational dust exposure in the miner's coal mine employment. Moreover, as discussed above, almost all of the physicians who addressed the issue concluded that the miner's totally disabling respiratory or pulmonary impairment substantially contributed to the miner's death. Thus, the crux of this issue is whether the miner's total disability arose from his coal mine dust exposure (*i.e.*, "Legal Pneumoconiosis"), and thereby hastened or substantially contributed to the miner's death. Finally, Dr. Rizkalla's opinion clearly supports the finding of death due to pneumoconiosis. Dr. Rizkalla cited the pathology evidence, other clinical evidence, and medical literature, and concluded that the miner's coal worker's pneumoconiosis was a substantial contributing factor in accelerating the miner's death.

Having carefully considered all of the evidence, I find that the death certificate, the Death Summary Report of Drs. Stemple/Dedhia, and the opinions of Drs. Rasmussen and Rizkalla are entitled to more weight than the contrary opinions of record. In making this determination, I find that the opinions of Drs. Morgan, Hippensteel, Renn, and Kleinerman are undermined by the latter physicians' failure to even diagnose pneumoconiosis. Moreover, the opinions of Drs. Stemple/Dedhia, Rasmussen and Rizkalla are most consistent with preponderance of the credible evidence, which establishes that the miner died a respiratory death; that the miner suffered from a totally disabling respiratory or pulmonary condition prior to his death; that the miner's total respiratory disability was significantly related to his 37 years of coal mine dust exposure (*i.e.*, "Legal Pneumoconiosis"); and that the miner's total respiratory disability substantially contributed to, and/or hastened, the miner's death. Therefore, I find that the Claimant has established that the miner's death was due to pneumoconiosis, as provided in §718.202(c)(2) and (4), (5).

Widow's Claim - Conclusion

Having considered all of the relevant evidence, I find that the Claimant has established that the miner had pneumoconiosis arising, at least in part, from his 37 years of coal mine employment;

and that pneumoconiosis was at least a substantially contributing cause or factor leading to, and hastening, the miner's death. Therefore, the widow's claim is also granted.

Entitlement to Benefits

Since the evidence does not establish the month of onset of total disability due to pneumoconiosis, benefits shall commence as of April 1, 1994, the month during which the miner filed his claim. For the purposes of augmentation of benefits under the Act, the miner had one dependent; namely, his wife, Margaret R. Earl. Since the miner died on May 13, 1998, his entitlement to benefits ended the month before the month during which he died (*i.e.*, April 1998). 20 C.F.R. §725.203. However, any underpayments which had been due the miner are payable to his surviving spouse, pursuant to §725.545.[5] Regarding the survivor's claim, benefits shall commence effective May 1, 1998, beginning with the month in which all of the conditions of entitlement prescribed in §725.212 were satisfied. *See also* 20 C.F.R. §725.213. Regarding the survivor's claim, however, there are no dependents, and, therefore, no augmented benefits. In summary, the Claimant, Margaret R. Earl, should receive all benefits which were due to her deceased husband, William L. Earl, with augmentation, and her own survivor's benefits, without augmentation.

ORDER

[5]Since the miner's claim was in pay status, there may not be any underpayment which was due the miner.

The claims of Willard L. Earl and Margaret R. Earl for black lung benefits under the Act are hereby **GRANTED**; and,

It is hereby **ORDERED** that Consolidation Coal Company shall pay to Margaret R. Earl, all benefits to which she is entitled under the Act, on behalf of the miner and as surviving spouse, as provided above, commencing as of April 1, 1994.

It is further **ORDERED** that Consolidation Coal Company shall reimburse the Secretary of Labor for payments made under the Act on the claims of Willard L. Earl and/or Margaret R. Earl, if any, and deduct such amount, as appropriate, from the amount it is ordered to pay under the preceding paragraph above.

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ROBERT J. LESNICK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal to the Benefits Review Board within thirty (30) days from the date of this decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.